	Child's Name:					DOB	20	
□ Summary of	Services							
□Physician's (
Early Intervention	Perso	Service co	ordinator ensures h (time			e provided)	Funding	*NE
Services	Agenc	all of the shild's convisces			cy (# of days	s or sessions)	Source	
& Intensity	Respo	identified and required			d (how service) I tion (place o		If Medicaid, MID #	Y or N
(individual/group)	Кезро	componen	ts are filled i	e filled in.			IVIID#	
					1			
			ator ensure					
		identified ar	itside service	es				
		ponents are	•					
*NE: If No, please comple	te the Natural Er	nvironment Ju	ustification pa	ige.				l
Other services the child			ing through	other sou	urces that	are not req	uired or fun	ded
by the Infant Toddler Program (Part C of IDEA) Service Coordinator ensures the anticipated outcomes for								
	the service and/or evaluation are specified.							
General Example:								
Diagnosis Description:		SLP is needed to address Joey's speech delay; or SLP is						
		needed to address Joey's 20% speech delay in expressive language; or OT evaluation is needed to address Joey's						
ICD-9 Code:			ine motor co			ccaca to a	uui 033 000	ys
Consent by Parents/G ICO Risk Factors Example:								
I participated in the development of this plan. I unde								
With receipt of my Procedural Safeguards, this p development, nowever based on parent and clinical and clinical services and clinical services are things and clinical services are the services as the services are the servi								
the provision of listed	services.		observations vould benefi					nd
 If there is an increase Program's System of 		or intensit	vould bellell	t iioiii ea	ily O1 to p	Jievenii iuli	uie delays.	
 The provision of listed 		es the comple	etion of ongoin	ng assess	men			
I give informed consent fo	r this Individualiz	ed Family Se	arvice Plan (II	ESP) to be	_	dates the	ardian signs olan	
_		ervice i lair (ii	01) 10 00	dia dia	·			
Parent/Guardian Signat		Date:						
Service coordinator en		Date:						
is sent to the physician								
prior to the parent sign signs and dates the ord	re and Financial Authorization							
their name, and identifies their clinic. and certify that they are medically necessary.								
.=			cerury urat trit	ey are me	•	•		
*Physician Signature: _						Date:		
Physician's Name (Typed	or Printed):					Clinic:		
I have reviewed and author	linator	d early inte			Service coordinator ensures			
Disabilities Education Act ensures the IFSP start						the addendum date and reason if not the initial or		
Lead Agency Authorizing date and 6 month rev			W C			annual is completed.		
	date is compl	eted.						
Date of IFSP:		nitial 🗌 A	nnual —	Addendum				
*6 Month review Reason for Addendum *The 6 month review date is not the expiration date of the physician's order. The physician's order expires 6 months from the date of the								
physician's signature.	•				•			
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